Nursing Home Workforce Stabilization Council
Meeting Minutes

Date Thursday, October 27, 2022, 1:00 p.m. – 4:00 p.m.

Location Conference Room 1A, 333 S. Grand Ave, Lansing, MI 48933

Council Attendance

Name	***Representing***	***Attendance***
Alison Hirschel	Residents	Present
Dian Palmer	Workforce	Present
Mark Berger	Employers	Present
Nancy M. Hebert	Workforce	Present
Erica Holman	Employers	Present
Jannice L. Lamm	Employers	Present
Mary McClendon	Workforce	Present
Michael Munter	Employers	Not Present
Martha M. Nichols	Workforce	Present
Robert L. Norcross	Employers	Present
Jennifer Root	Workforce	Present
Terence Thomas	Residents	Present
Yvonne M. White	Advocates	Present
Salli Pung	Residents	Not Present

Michigan Department of Health and Human Services (MDHHS) Staff:
Farah Hanley, Meghan Groen, Nicole Hudson, Kenny Wirth, Kate Tosto, Erin Emerson Lauren Swanson-Aprill
Licensing and Regulatory Affairs (LARA) Staff:
Adam Sandoval, Jennifer Belden, Courtney Adams
Labor and Economic Opportunity (LEO) Staff:
Valerie Jemerson
Guests:
Bethany Duyser (IMPART Alliance), Dr. Clare Luz (IMPART Alliance)

Minutes: The Nursing Home Workforce Stabilization Council meeting was held in-person and virtually on October 27, 2022 with twelve (12) councilmembers in attendance.
Quorum was fulfilled.

1. **Council Business**
   Presented by Farah Hanley and Kenny Wirth
   A. Meeting called to order at 1:10pm
   B. Welcome and Introductions
   C. Hybrid Meeting Housekeeping

2. **Finalize Talking Points**
   Presented by Farah Hanley
   A. Review and Approval
      - J. Root – would like to see “staffing” stated more explicitly as the largest issue.

- E. Holman – more about what evidence-based sources are going to be used. How we will ensure that recommendations are evidence-based.

3. Survey Discussion

Presented by Kate Tosto

A. Review further data related to burnout

B. Ideas/suggestions from workforce

- See meeting materials for slides
- M. McClendon – Staffing is always an issue. There is never enough staff. Staff underpaid.
- M. Nichols – Increase in pay would attract more staff.
- M. McClendon – Discusses "bonus hopping." Staff staying long enough at building offering a sign-on bonus. Once sign-on bonus received, they leave for another building offering a sign-on bonus and continue repeating the pattern.
- B. Norcross – costs already increasing by 20-40% to keep up with inflation.
- J. Root – need some sense of retirement security.
- E. Holman – (Example job supports from her organization) provide staff 75% of tuition for higher ed, feed meals during day, massage chair, career ladder, mentor program, matching retirement funds (4% out the door for 403(b)). Struggling to get nurse aides in the door.
- N. Hebert – vast difference between non-profits and for-profit industries. Need to treat all jobs within nursing homes as careers and long-term employment, not transitory job before becoming a nurse or other profession.
- B. Duyser – inability to provide adequate care due to time constraints. No amount of money could keep someone in a role where they are unable to take breaks or adequately care for patients.
- D. Palmer – Work is very physical, around the clock. Need to come up with unique ways to schedule shifts to allow for more family time. Many workforce members struggle with having to work their shift and find someone to pick their kids up from work, then need to care for family members after working a full shift. Need to not only increase the pay but come up with some creative solutions to schedules.
    - Constantly called on days off, then escalates to work mandates on days off. When working at hospital in Wisconsin, had some staff that only worked on the weekends. Also at a different hospital, worked 7 days on, 7 days off – essentially on vacation every other week.
    - Help people do the job, get paid a decent wage, make it worth their while to leave the home and their family.
    - also concerned about younger workers getting injured on the job due to non-functioning equipment
- M. Berger – when agency brought in, it is the staff who are challenged. Costs are elephant in the room. So many have left industry, now

question is how do we get people back into the industry? And how do we retain the people who have endured COVID in the facilities to ensure that they can stay and maintain quality life through inflationary period of time. Costs have gone up 20-25% and continue to go up. Most businesses able to increase their pricing to keep up with increasing costs. Our concern as partners of the State is that we don't have the ability to increase pricing – we need those dollars from our partners. Question is how we increase the dollars to get to do some of these programs we have talked about – we need to do more, want to do more. Career paths, wages, benefits – all good suggestions, but we need to figure out the funding to get to do this.

- A. Hirschel – has to be a willingness to spend money on programs if we want them to be implemented. issue a bit more complicated from resident advocacy perspective. Not enough transparency and accountability currently for how reimbursement is being spent and where that money is going. We all want nursing homes to be able to attract good staff and pay living wages, but hard to talk about providing more money if we don't know where existing money is going right now. Reimbursement is a very complicated issue, but this is a piece of the puzzle.
- E. Holman – Allison's point salient. Every operator in state is audited when submitting cost report. Non-profits have a second audit process. Transparency not only on provider part, accountable to the citizens. Also required to be good fiscal stewards. A good thing to look at whether this data is available.
- M. Berger – Cost reports are a requirement and are public information. Every last dollar has to be accounted for. Every year, every cost report is audited.
- A. Hirschel – Increasing transparency and accountability in nursing homes is a national issue right now. Nursing Home corporations sometimes have many entities involved in corporate structures – hard to tell how much money is going to profits and how much is going to care. All answers aren't entirely in the cost reports due to complicated corporate structures and how the money flows. Perhaps not as easy to gather information as characterized.
- M. Berger – Point of clarity. Conversation is centered around large corporations that are not operators. We need to focus on operators and day-to-day costs. Agree that the large corporations are an issue that needs to be discussed on a national level. What we need to discuss are costs and the level at which they have risen.

4. **BREAK**

5. **IMPART Alliance**
   Presented by Dr. Clare Luz, PhD, Michigan State University & IMPART Alliance
   A. Presentation

Nursing Home Workforce Stabilization Council
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- Working definition of Direct Care Worker
    - Provide essential services through behavioral health, community mental health and long-term care systems including PACE to support individuals with disabilities and older adults in a range of settings including private homes, group homes, assisted living facilities, nursing homes, and community living supports settings.
    - Go by many titles including, but not limited to, certified nursing assistants, home health aides, hospice aides, personal care assistants, direct support professionals, self-directed home care workers, and home care companions.
    - Distinguished by core tasks shared by most DCWs that generally include assisting with hands-on personal care, activities of daily living, instrumental activities of daily living, vocational assistance, and rehabilitation.
    - Are mostly paid through Medicaid but may also be covered by private insurance, Medicare, directly by clients, or other funding sources.
- Why is there a DCW Shortage? Lack of economic security due to:
    - Low wages & benefits
    - Lack of guaranteed hours
    - Lack of training
    - Lack of career advancement options
    - Lack of societal value placed on direct care work
    - Institutional & historical racism, sexism, agism, and discrimination against immigrants and persons with disabilities
- Estimated that we need about 196,000 skilled DCWs
    - This is 36,000 more than are working in these MI jobs today
    - Very high turnover rate, with high costs attributed to turnover
- Four Primary Questions:
    - How do we attract DCWs?
    - How do we keep DCWs?
    - How do we make sure that DCWs are competent?
    - What needs to change to achieve competency, recruitment and retention goals?
- Three strategies to raise economic security, equity, and respect
    - Increase wages & benefits
    - Professionalize the DCW workforce by establishing:
        - Competencies, Professional and Ethical Standards
        - Training Guidelines & make training accessible & affordable
        - Credentials
        - Career Pathways
    - Culture Change – increase the value placed on direct care work
- 2021-23 Michigan State Plan on Aging: The Direct Care Workforce is a Priority

  - Increase number of qualified and supportive multicultural direct care workers
  - Support opportunities to increase wages
  - Improve retention
  - Elevate this workforce by promoting its collective value
- DCW Statewide Advisory Council
  - Competency, Education, Credentialing, Career Pathways Workgroup
    - Goal – professionalize the DCW workforce
    - Competency guidelines/standards – created and approved by MDHHS leadership
    - Professional and ethical standards
    - Education and training guidelines
    - Competency based, person-centered training models with test-out options, reciprocity, flexibility, portability
    - Certification/credentialing
    - Career pathways and success
- MI Dept. of Labor and Economic Development – Workforce Development MICA 3.0 (Michigan Industry Cluster Approach) Project
  - Industry Collaborative to Expand Direct Care Across Michigan DCW Expansion Collaborative
  - MICA Project Goals & Progress
    - Begin to form a statewide, employer-led, industry collaborative that will advance the DCW workforce by addressing recruitment, retention, and skills gaps
    - Produce a talent pipeline and career pathways plan that includes:
      - Identifying all talent sources and strategies for successful recruitment in these new labor pools in order to widen DCW pipeline
      - Develop virtual DCW stackable curricula that aligns with the competencies endorsed by the MDHHS DCW Advisory Committee
      - Develop and pilot test virtual Master Trainer and Train-the-Trainer programs to increase number of Trainers who can virtually train the new DCWs.
      - Develop a plan for establishing DCW competency-based credentials
      - Identify well-articulated career pathways that provide advancement opportunities within an outside of the Collaborative members.
      - Launch a marketing campaign to raise DCW career awareness, public value placed on the DCW workforce, and policy maker education to support and promote this workforce through policy and regulatory reforms

- Essential Jobs, Essential Care (EJEC): Policy Advocacy Initiative
    - IMPART Alliance and PHI Partnership: Formation of the IMPART Alliance statewide DCW Coalition to help drive policy strategies that strengthen Michigan's DCW workforce
    - Policy Road Map
    - Annual Summit
    - Coalition mobilized members to contact legislators regarding $2.35 wage increase
- Successes
    - Premium pay for DCWs (COVID response): Legislature and Governor made the $2.35/hour increase permanent – it was included in the FY22 approved budget
    - Competency guidelines adopted
    - Code of ethics and professional standards adopted
    - Curricula, Credentials, Career Pathways in progress
    - Training infrastructure proposal in the state budget
    - PPE/vaccine policy briefs – PPE supplies and vaccine FAQs
    - Michigan Care Career DCW/Employer online platform under development
- Key Components of Success
    - Statewide leadership – cutting across sectors, programs, settings, payors, populations
    - Inclusive of all stakeholders
    - Building relationships based on respect, transparency, trust, collaboration vs. competition
    - Recognition of interrelatedness of solutions
    - Finding common ground and goals
    - Common definition of DCW
    - Advocacy on behalf of all DCWs
    - Neutral convener
    - Commitment, passion, patience, and persistence
- Next Steps
    - Complete Crosswalk of DCW Recommendations from key sources & identify best next steps for MI
    - Living wages/benefits with COLA, overtime, paid time off, etc.
    - Raising Medicaid reimbursement cap
    - Professional and reimbursement occupational codes for DCWs
    - Quality standards built into contracts
    - Affordable, accessible training
    - A data infrastructure
    - Tackline underlying causes of shortage: racism, sexism, ageism
    - Advocating for reforms and solutions that provide economic security for DCWs and competent, compassionate care for individuals needing support

B. Questions & Answers

- V. Jemerson – wages are number one item discussed at all workforce-focused groups. Each of these groups need to connect on issue of wages and come up with cohesive strategy. Many states have answers to these questions, why can't we use what other states have done to bring everyone to the table to create a plan. Wage issue is first thing that needs to be addressed – this is where we need to build from.
- C. Luz – When considering wages, CHCS did a study and provided recommendations to Michigan. Subgroup is working to see which recommendations are in progress and which recommendations should be worked towards. This subgroup is now building a crosswalk to determine the different ways to address wages. Hoping to complete this crosswalk by the end of the year.
- V. Jemerson – important to provide education and information to operators of nursing homes. Need to be standards for how people are treated and spoken to. Some sort of basic training to develop skills for creating a culture of support.
- C. Luz – everything with MICA grant can now flow into larger training infrastructure grant. Training for mid-level management and administrators is part of this grant. Also need to be able to train the trainers. There are management/supervisory trainings out there, challenge is how do we apply persons-centered thinking to your staff and not just to your residents?
- V. Jemerson – we need to address wages and career pathways before we can advocate for people to join the career. We need to show people that their work is valued and respected. Career pathways have to be defined and deliberate. Also need to provide a working environment where employees can both work and go to school, not having to sacrifice one or the other.
- M. Berger – Practical opportunities presented, seem to be on the right path with this discussion.
- B. Norcross – Agrees with the sentiment.
- Y. White – Excellent presentation. Wondering about Occupational Health and Safety measures. Can anyone speak to what is being done and the discussions that have been had?
- C. Luz – Wouldn't be able to speak to OSHA standards or how we could work with them for positive change. Agrees that this is an area we need to be looking at. So many work-related injuries to direct care workers, something needs to be done in this area.
- Y. White – even with workers who are satisfied with wages and benefits, health and safety of the workers is never discussed in these meetings. This is something that needs to be discussed more.
- C. Luz – A lot of this has to do with availability of equipment and staffing ratios. Not knowing how to use the equipment should not be an excuse. Everyone in a building should know how to use the equipment.
- A. Hirschel – hears a lot from ombudsmen who hear from staff that injuries are common, along with physical exhaustion and stress

- L. Swanson-Aprill – collaborative efforts going on with Direct Care Workforce Advisory Committee. Looking forward to continued collaboration with the Nursing Home Workforce Stabilization Council.

6. Council Discussion

A. December Agenda

- N. Hudson – any topics or pieces to spend more time on at December meeting?
- V. Jemerson – would like to hear more about Health and Safety aspect. Having a safe work environment ties into feeling respected and valued in the workplace. If any operators have best practices in place, would like to hear from them.
- J. Lamm – Currently struggling with staffing in building and needed to make difficult decision to bring in agency staff. Would be great for Council to show support for HB 6364, which has to do with capping pay for agency staff.
- K. Wirth – We can look into this. Unsure of Council's ability to advocate for legislation, but individual council members are able to reach out to their legislators to advocate for this bill. We will circle back on whether the Council is able to make this type of advocacy effort.
- B. Duyser – If looking at State level OSHA for workplace protection, some lessons learned from COVID-19 is integrating long term supports and services in regional health departments. PPE sharing and vaccination sharing was critical early on and facilitation assisted by regional health departments. Occupational Health and Safety would fit nicely into that information sharing.
- N. Hudson – Building off of that, regional health care coalitions are great partners with distributing PPE. This is another resource on the ground that we could look into as well.
- D. Palmer – Is there any state in the US that has "nailed it" with regard to long-term care?
- C. Luz – Not really, but other states do have some good things happening.
- N. Hudson – If there isn't one state that has done everything well, we can find the states that have successfully addressed wages, or benefits, etc. Then we could try to blend the best of the best to pull from states that have done certain things right.
- C. Luz – Millbank report includes lots of good information about what other states have done and what other states should consider implementing. Also working on a crosswalk of recommendations from multiple different reports to pull the best recommendations from each report. Hoping to complete this report by end of year, then happy to provide a presentation on findings.
- D. Palmer – With the agencies we are trying to cap the pay on, are we able to do what these agencies do inside the nursing home? Wages and flexible hours are probably what is appealing about agency. Is

there a way to duplicate this inside the nursing home? Also – sees signs around Michigan for McDonalds and how much you can make working there and it is normally more than what can be made in nursing homes. Some have spoken about raising reimbursement rates today, is this something that we could talk about in the future?

- E. Holman – We are reimbursed based on our cost reporting. It normally takes 2-3 years for the reimbursement rates to catch up with our cost reports. For the base employees, we do get reimbursed for raising their wages, but due to the lag and rates not being raised in real time, this leads to a challenge in raising wages. With 2.35 staying in place in Michigan, this will help. But housekeepers deserve this. Food services staff deserve this.
- N. Hudson – Reimbursement rates is something we could discuss in this council and is a recommendation that could go up to the Governors office. We can look at different models of reimbursement to see if there are alternatives that would be worthwhile to discuss.
- D. Palmer – Trying to figure out ways to get a better life for folks who are caring for all of us when we are older.
- J. Root – where are the pressure points for us to impact change? We can discuss the changes that are needed, but we need to know who the decision makers are so that we know where to apply the pressure to make changes.
- C. Luz – Another place to look is the staffing ratios. These are always coming up in discussions, so how could we improve the staffing ratios.
- A. Hirschel – Because focus of this group is the workforce stabilization, any recommendations that we make about reimbursement and increasing reimbursement rates, we need to make sure that that reimbursement goes directly to direct care workers and directly to things that increase the residents' care and quality of life. Any money coming out of recommendations made by this Council needs to be directed at addressing the crisis we are trying to solve.
- D. Palmer – Is there a way to make sure that people don't need to jump through hoops to get the higher wages or trainings needed to advance career?
- C. Luz – adding on to that, a large portion of DCWs are on public assistance because they cannot afford to live on the wages they get. There is a Catch-22 where if you make more money, you no longer qualify for public assistance. Called the Benefits Cliff. The trick is to get wages high enough so that when you are eventually off of public assistance, you aren't in a tougher spot than when you were being paid less. Need to make sure that folks are better off when they make more money and are off of public assistance, not that they are worse off after receiving a raise.
- B. Duyser – recurring pattern in literature is importance of shared decision making in long-term care. Lots focuses on shared-decision making in resident care planning. Looking at this group as a shared-

decision making mechanism, what are the requirements for shared-decision making to include DCWs in discussion around reimbursement? How does shared-decision making regarding reimbursement rates look at the state level?

- N. Hudson – We will probably save reimbursement for January to allow us time to collect the right information and bring in the right people.
- J. Root – Understanding which streams of money go to which things is important. What is the accountability for each stream of money? Regarding the staffing ratios, not just what the ratio is, but who is included in the ratio – e.g., job descriptions, etc.
- C. Luz – B. Duyser researching interdisciplinary care planning and shared decision making. Direct care worker should be included in these meetings.
- B. Duyser – if we are going to be looking at staffing ratios, would be good to look at staffing based on acuity or intensity vs. number of patients. Currently CNA staffing is based on number of patients, but the time to care for a patient varies based on the patient's needs.

B. Future Meeting Dates

- N. Hudson – next meeting will be held December 1. Would like council's input on whether to hold meeting virtually or in-person?
- No opposition to virtual. Support heard from multiple members.
- Future meeting dates presented:
  - December 1, 2022
  - January 26, 2023
  - February 23, 2023
  - March 23, 2023

7. **Public Comment**
   Public comment facilitated by Kenny Wirth
   - None.

8. **Adjourn**
   Meeting adjourned at 3:51pm.

Next meeting scheduled for December 1, 2022 at 1:00pm.